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CASE REPORT

A Rare Case of Non-puerperal Acute Uterine Inversion

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Case Report

A forty-year-old female hailing from Raigad presented in casualty on 14 Jan 2011 at 6.40 pm with something coming out per vaginum for the last 4–5 days, backache, abdominal pain, and a foul odor discharge per vaginum. Her last menstrual period was on 9 Jan 2011. Her periods were relatively heavy; however, she had not sought consultation for the same. There were no other menstrual, bowel, or bladder complaints. She was married for 26 years and had four vaginal deliveries; the last child was 10 years old. Her past medical, surgical, and family histories were not of clinical relevance.

On systemic examination, she was conscious and cooperative, but markedly pale with a pulse rate of 78/min, blood pressure of 100/60 mmHg. On per abdomen examination, the abdomen was soft; there was mild tenderness in the hypogastric region. On per vaginum and per speculum examination, a huge mass of 10 by 10 cm size was seen to have prolapsed from the vagina with a 4-cm-sized gangrenous area on the cervix with clear margins with maggots and foul odor. The mass could not be reposited. The cervical opening was not visualized. However, there was a small dimple at the tip of the necrosed mass, mimicking the "os." Bilateral fornices were tender. There was no evidence of cystorectocele or vaginal or parametrial involvement. A provisional diagnosis of acute inversion of the uterus with septicemic shock was made. On per rectal examination, the uterus could not be felt. Her laboratory investigations revealed hemoglobin of 5–6 g % with leucocytosis. She was immediately started on higher antibiotics and three units of blood were transfused, and her condition stabilized with IV fluids and analgesics.

An abdominal sonography was done, which revealed a prolapsed uterus with normal renal parameters. The patient was treated with daily betadine dressing and with subsequent corrective surgery.

Examination under anesthesia confirmed that the dimple on the necrosed mass was not the cervix as the uterine sound could not be negotiated through it. The cervical opening was not seen. Reposition of the mass was not possible. Anteriorly, the bladder was reflected behind; however, the fundus of the uterus was not palpable. The diagnosis of acute inversion of the uterus was confirmed. A thick fibrous circumferential band near the vulva was suggestive of the obstructive ring through which the fibromyoma attached to the fundus (at the dimple), and must have incarcerated leading to necrosis of the prolapsed fibroid. The fibroid was enucleated from the fundus. The fibrous ring at the cervix could not be cut effectively so as to conserve the uterus. So, with regards to the age of the patient, parity, and complications, vaginal hysterectomy was performed.

Her postoperative course in the ward was uneventful. She was given intravenous ferrous sucrose injection and

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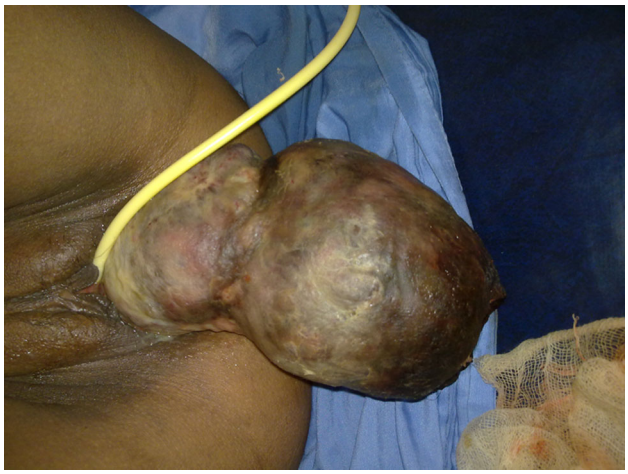

Fig. 1 Uterine inversion by a huge fibromyoma with gangrenous tip

discharged on the 5th postoperative day. However, the patient did not come for a follow-up visit which was scheduled a week later (Fig. 1).

Discussion

This case of acute uterine inversion in a non-pregnant state is one of a kind. Acute inversion of the uterus generally complicates the third stage of labor, and is most commonly associated with inadvertent delivery of the placenta [1], whereas cases of chronic inversion have been reported so far in non-puerperal patients [2].

In the present case, the pull of a huge fundal fibromyoma was responsible for the acute inversion, following which the tumor got entrapped in the cervical inversion ring leading to necrosis and sepsis. Ideally, a vaginal myomectomy is performed followed by an incision of the incarceration ring so as to reposit the uterus thereafter in young patients where conservation of the uterus is desired. Delay in treatment of acute inversion causes dense constriction ring formation, progressive edema, and tissue necrosis, and thus the uterus cannot be reposited by vaginal manipulation.

The surgeries for reposition have been described by the abdominal and vaginal routes by Huntington, Haultain, Spinelli, and Kustner [3]. In our case, the patient was in a perimenopausal age group and a part of the fundus near the attachment of the fibroid was already necrosed. So, a vaginal hysterectomy was the obvious choice.

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